|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal Accident and Sickness Claim Form** | | | | | | | | | | | | | | |
| Organization: **Harness Racing Victoria** | | | | | | | | Policy Number: **241885501349** | | | | | | |
| Please note that this not Work Cover as participants are not employees of HRV and therefore not covered under HRV’s Work Cover policy. Medical and hospital expenses should be processed via Medicare and your private health insurance (if held). If you are employed by a trainer and paid, they should have a Work Cover policy that covers you. | | | | | | | | | | | | | | |
| **TO BE COMPLETED BY THE CLAIMANT - 1** | | | | | | | | | | | | | | |
| Claimants Name: | |  | | | | | | | | | | | | |
| Job Title: | |  | | | | | | | | | | | | |
| Work Site / Location: | |  | | | | | | | | | | | | |
| Home Address: | |  | | | | | | | | | | | | |
| Telephone (private) | |  | | | | | | Telephone (work) | | | |  | | |
| Telephone (mobile) | |  | | | | | | **Email (important)** | | | |  | | |
| Date of Birth | |  | | | | | | | | | | | | |
| Height | |  | | | | | | Weight | | | |  | | |
| For what are you claiming? | | | Loss of Income Weekly Benefits | | | Capital Benefit (e.g. Loss of limb) | | | | Death | | | Reimbursement of (Non medicare) medical expenses | |
|  | | | | | | | | | | | | | | |
| **INJURY or SICKNESS DETAILS:** | | | | | | | | | | | | | | |
| What is the injury or illness? | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| If injury, how exactly did it occur? | | | | | i.e. playing sport, etc. | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| When did the accident/sickness first occur? | | | |  | | | | | | | Time am/pm | | | |
| Are you employed? | | | | | | | Full-time | | Part-time/Casual | | | | | Self-employed |
| Did the injury or illness cause you to stop work? | | | | | | | Yes  No | | If Yes state when | | | | | / / |
| Have you returned to work full-time? | | | | | | | Yes  No | | If Yes state when | | | | | / / |
| Have you returned to work part-time? | | | | | | | Yes  No | | If Yes state when | | | | | / / |
| – if Yes, what hours and duties are you working? | | | | | | | Days Hours | | If Yes state when | | | | | / / |
| Is this condition due to injury or sickness arising out of your participation in Harness Racing ? | | | | | | | | | | | | | | Yes  No |
| - If yes give details |  | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **TO BE COMPLETED BY THE CLAIMANT - 2** | | | | | | | |
| **Who is your usual family doctor?** | | | | | | | |
| Name |  | | | | Telephone Number |  | |
| Address |  | | | | | | |
| How long have you been going to this doctor? | | | |  | | | |
| **What is the name of the doctor you first consulted for this condition?** | | | | | | | |
| Name |  | | | | Telephone Number |  | |
| Address |  | | | | | | |
| When did this consultation take place? | | | | | | | / / |
| **Have you consulted any other medical practitioner for this condition?** | | | | | | | Yes  No |
| Name |  | | | | Telephone Number | |  |
| Address |  | | | | | | |
| When did you first see this doctor? | | | | | | / / | |
| **Did you go to hospital?** | | | | | | Yes  No | |
| Hospital Name |  | | | | Telephone Number |  | |
| Address |  | | | | | | |
| Admission Date | / / | | Discharge Date | | / / | No of Days . | |
| **During the 24 hours before the injury, did you drink any alcohol or take any drugs?** | | | | | | Yes  No | |
| State types & quantities | | |  | | | | |
| **Have you ever had this or a similar condition in the past?** | | | | | | Yes  No | |
| Diagnosis / Treatment Received |  | | | | | | |
| Treatment Start | / / | | Treatment Completed | | / / | No of Days . | |
| Doctor’s Name |  | | | | Telephone Number |  | |
| Address |  | | | | | | |
| **What other significant medical or surgical treatment have you had in the past 5 years?** | | | | | | Yes  No | |
| Diagnosis / Treatment Received |  | | | | | | |
| Treatment Start | / / | | Treatment Completed | | / / | No of Days . | |
| Doctor’s Name |  | | | | Telephone Number |  | |
| Address |  | | | | | | |
| **Are you affected by any other long term or chronic disability** | | | | | | Yes  No | |
| Provide Diagnosis / Treatment Details | |  | | | | | |

|  |
| --- |
| **TO BE COMPLETED BY THE CLAIMANT - 3** |
| **OTHER INSURANCE / BENEFITS CLAIM** |
| Are you claiming insurance or compensation from any other insurance company? e.g. Workers Compensation, Traffic Accident Commission, CTP, sports body or any income replacement.  Yes  No |
| Are you receiving sick leave or any other entitlements from your employer? .  Yes  No  N/A (self-employed) |
| Provide Details: |
| Name of Insurer, Claim Number & Telephone number |
| Type of cover |
| Amount claimed per week / amount received |
|  |
| **PRIVATE HEALTH COVER** |
| Do you have private health insurance?  Yes  No |
| Provide Details / Claim Number |
| Do you have ambulance cover?  Yes  No |
| Provide Details |
|  |
| **PAYMENT OF BENEFITS** |
| Should your claim be successful you may have your payments made by cheque or by EFT directly to your bank.  Please choose:  Cheque or  EFT |
| **EFT AUTHORISATION**  I hereby authorise and request that SLE credit my bank account as indicated below:  Name of Bank…………….……………Branch Address………………………………..…BSB No: ………………………..….  Account No:………………………………Account Name…………………………………………………..…………………….  Please note that if you elect to receive payments by EFT then SLE accept no responsibility for the incorrect allocation of these payments by the EFT Authorization Bank / Building Society or Credit Union. |

|  |  |  |  |
| --- | --- | --- | --- |
| **TO BE COMPLETED BY THE CLAIMANT - 4** | | | |
| **PRIVACY CONSENT - CLAIM ASSESSMENT** | | | |
| Protection of My Privacy, Acknowledgement and Consents  By signing this form I agree that SLE Worldwide (including the Insurers they represent and claims management services) and third parties such as my insurance broker, claims reference services, government organisations (for example social security agencies or taxation offices), any forensic accountant retained by SLE, my employers (past and present), my accountant, any business which provides information about the commercial activities of persons and if I am or have been bankrupt, the trustee of my estate (‘the Parties’) may exchange with each other any information about me, excluding health or other sensitive information, including:  • Any information provided by me in relation to my claim;  • Any other personal information I provide to any of them or which they otherwise lawfully obtain about me;  • Any information relating to this insurance or any other insurance held by me or on my life, including terms and conditions and claims history;  • Details of my employment, including position, period of employment, remuneration, hours worked and duties performed; and  • Any information relating to my income and solvency.  I agree that any information referred to above can be used by the Parties and any Service Provider (as identified below) for assessing the claim or my entitlement to benefits and, if the claim is accepted, for administration of the claim and for planning, product development and research purposes.  I agree that SLE may exchange my personal and/or sensitive information, for the purposes of assessing the claim or my entitlement to benefits with:  • Any investigator appointed by SLE to investigate the claim;  • The Health Record Holders;  • The Health Insurance Commission;  • Other insurers;  • Re-insurers;  • Any private or government organisation which investigates fraud including the police; and  • Any witness identified by me.  If I have identified any person as a witness, I agree to ensure that each person is made aware that:  • I have identified him/her as a witness in relation to the claim;  • SLE holds a record of their personal information for this purpose; and  • He/she may contact SLE or request access to his/her information.  If SLE engage anyone (a ‘Service Provider’) to do something on its behalf (for example technology providers) then I agree to them exchanging any information referred to above, with each other.  I understand SLE might give any information referred to above to entities other than the Parties, the Service Providers, the Health Record Holders and the other persons/organisations referred to above where it is required or allowed by law or where I have otherwise consented. I understand that I can access\*\* most personal information that members of SLE hold about me (sometimes there will be a reason why that is not possible, in which case I will be told why). I understand that if I fail to provide any information requested in this form, or do not agree to any of the possible exchanges or uses detailed above, SLE may be unable to assess the claim.  \*\* To find out what sort of personal information SLE have about you, or to make a request for access, call Aon on 03 9211 3646 | | | |
| **MEDICAL AUTHORITY, DECLARATION AND POWER OF ATTORNEY** | | | |
| **\*\* I…………………………………………………………………………….[insert name block capitals] DECLARE THAT**,  • I will use my best endeavors and render all reasonable assistance and co-operation to SLE Worldwide in the assessment of my claim;  • the information supplied by me is true and correct and that I have not withheld any information likely to affect the acceptance of the claim;  • I understand that the claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts;  • I understand that by investigating my claim or by accepting proofs of my claim, SLE has made no acceptance of liability, nor waived any of its rights in defense of any claim arising under the policy.  I hereby appoint SLE to do everything necessary or expedient to:  • give effect to the transactions contemplated by the authorisations described; and  • execute and deliver any other documents or do any other acts referred to in the transactions described.  I hereby authorise any person, corporation, institution, private or government organisation, whether named by me or not, to provide such information as SLE in its absolute discretion considers relevant for its assessment of initial or ongoing benefits for my claim including, without limitation:  • all medical, surgical or other information concerning myself, my medical history, any treatment received by me and any medication taken or prescribed for me (at any time);  • my Health Insurance claims history, including Medicare;  • any information in relation to my assets, liabilities, earnings, salary or wages (at any time);  • any information from third persons who may have information relevant to my eligibility to receive a benefit, or my entitlement to receive an ongoing benefit. | | | |
| **SIGNATURE OF CLAIMANT:** |  | **DATED** |  |
| **SIGNATURE OF WITNESS:** |  | **DATED** |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TO BE COMPLETED BY PERSON MAKING A CLAIM FOR DEATH BENEFIT.** | | | | | | | | | | | | |
| Name of Person Completing the Form | | | | |  | | | | | Telephone Number | |  |
| Email address | | | | |  | | | | | | | |
| Company Name (If applicable ) and Address | | | | |  | | | | | | | |
| Relationship with deceased – tick box below: | | | | | | | | | | | | |
| Employer |  | Next of kin |  | Executor | |  | Family Doctor |  | Lawyer | |  | Other |
| If next of kin state family relationship | | | | |  | | | | | | | |
| **THE FOLLOWING DOCUMENTS MUST BE INCLUDED WITH THIS CLAIM:**  - Certified copy Death Certificate.  - Certified copy of Original Birth Certificate  - Copy of the Coroner’s Depositions & Findings (if applicable). | | | | | | | | | | | | |
| Was a coronial inquest held or is one being held? If so give details | | No  Yes |  | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TO BE COMPLETED BY YOUR DOCTOR - 1** | | | | | | | | | | | | | | | | | | | |
| **MEDICAL PRACTITIONER’S STATEMENT TO COMPANY** | | | | | | | | | | | | | | | | | | | |
| The claimant is responsible for any fee for this statement. This form should be **FULLY** completed and returned promptly | | | | | | | | | | | | | | | | | | | |
| Patient’s Name | |  | | | | | DOB | |  | | Height |  | | | | Weight | | |  |
| **Diagnosis** (if fracture or dislocation, describe nature and location i.e.: Simple, Compound | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| Cause:- | |  | | | | | | | | | | | | | | | | | |
| If available please provide a copy of X-ray report | | | | | | | Is this condition  an injury or  an illness | | | | | | | | | | | | |
| Does the patient have any other injury or illness that is contributing to the condition? e.g. Osteoporosis | | | | | | | | | | | | | | | | | | Yes  No | |
| Provide Details | |  | | | | | | | | | | | | | | | | | |
| Is condition due to injury or sickness arising out of the patient’s employment? | | | | | | | | | | | | | | | | | | Yes  No | |
| Provide Details | |  | | | | | | | | | | | | | | | | | |
| Was the disability sports related? | | | | | | | | | | | | | | | | | | Yes  No | |
| Provide Details | |  | | | | | | | | | | | | | | | | | |
| Date of onset/first symptoms? | | | | | | | | | | | | | | | | | | / / | |
| When did the patient first consult you for this condition? | | | | | | | | | | | | | | | | | | / / | |
| Has the patient ever had the same or similar condition? | | | | | | | | | | | | | | | | | | Yes  No | |
| From when & Diagnosis | |  | | | | | | | | | | | | | | | | | |
| Name of patient’s usual doctor/medical practice | | | | | | |  | | | | | | | | | | | | |
| How long have you been the patient’s usual doctor/medical practice? | | | | | | | | | | | | | | | | | |  | |
| Has the patient been hospitalized | | | | Date of Admission | | | / / | | | Date of Discharge | | | | | | | | / / | |
| Name of Hospital | |  | | | | | | | | | | | | | | | | | |
| Has the patient had surgery or is it anticipated? | | | | | | | | | | | | | | | | | | Yes  No | |
| Provide Details | |  | | | | | | | | | | | | | | | | | |
| Date performed or anticipated | | | / / | | | | Give name of hospital? | | | | | | |  | | | | | |
| Did you provide other medical services (including pathology) to the patient? | | | | | | | | | | | | | | | | | | Yes  No | |
| Provide Details | | / / | | |  | | | | | | | | | | | | | | |
| / / | | |  | | | | | | | | | | | | | | |
| Was the patient referred by you or to you? | | | | | | | | | | | | | | | | | | Yes  No | |
| Provide Details | | / / | | | Doctors details | | |  | | | | | | | | | | | |
| Is the patient still disabled? | | | | | | | | | | | | | | | | | | Yes  No | |
| If yes | Totally disabled (unable to perform any part of their occupation) | | | | | | | | | | / / | | | | to | | | / / | |
| Partially disabled (able to perform part of their occupation) | | | | | | | | | | / / | | | | to | | | / / | |
| If partially disabled, what duties could the patient perform and for how many hours a week? | | | | | | | | | | | | | | | | | | Hours | |
| Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, Workers Compensation insurer, Social Security, sports body or any other insurance body? | | | | | | | | | | | | | | | | | | Yes  No | |
| Name of Company / Contact / Claim number | | | | | |  | | | | | | | | | | | | | |
| **SIGNATURE OF MEDICAL PRATICTIONER:** | | | | | |  | | | | | | | **Date** | | | |  | | |
| **NAME + QUALIFICATIONS (PRINT):** | | | | | |  | | | | | | | **Telephone** | | | |  | | |
| **ADDRESS** | | | | | |  | | | | | | | | | | | | | |

|  |
| --- |
|  |
| **WHAT TO DO**   1. Please complete all sections of this form (state N/A if not applicable). Ensure that the claimant, Employers and Medical Practitioner have signed this form. 2. Send this form to:   SLE Worldwide  [claimsenquiries@sleworldwide.com.au](mailto:claimsenquiries@sleworldwide.com.au)  or: Aon  [aaron.sparkes@aon.com](mailto:aaron.sparkes@aon.com) |
|  |
| **DISPUTES**  SLE has developed an internal procedure for dispute resolution so that if at any time our products or services have not met your expectations You or an Insured Person can contact Us.  Our Complaints and Disputes Resolution procedures will refer the complaint to senior management for review and a response within 10 working days.  If this does not resolve the issue or You or an Insured Person are not satisfied with the way a complaint has been dealt with, we will provide You with access to the applicable insurer’s Internal Dispute Resolution Committee who can review Your complaint.  If You or an Insured Person are still dissatisfied, the complaint may be referred, at no cost to you, to the Financial Ombudsman Service operated by Financial Ombudsman Service Limited under the terms of the General Insurance Code of Practice. |
|  |
| **PRIVACY**  SLE Worldwide has always protected the privacy of personal information of our valued clients. The standards by which we handle this personal information have now been set by the Privacy Act and the National Privacy Principles (NPP), which came into effect on 21st December 2001.  All Staff, Broker Representatives, Agents and Contractors have agreed to hold all information in confidence and not use it for any purpose except to carry out the service they are providing. We do not sell or share names, addresses or any other information with third parties, except to the extent necessary to complete our obligations as an Underwriting Agency or as stated in this document.  **How & why do we require your Personal Information**  We collect information either directly from the relevant individuals or in some cases, from third parties. They may provide information for someone else requiring the benefit of the services that we offer, such as a nominated driver, director or officer or other staff member.  The information is collected to allow us to provide our insurance services including to arrange and place insurance cover, assess and underwrite risks, and to properly administer your claims.  **What we expect of you**  When you provide us with information about other individuals, we rely on you to have made, or make them, aware that you will or may provide their information to us, the types of third parties we may provide it to, the relevant purposes we and the third parties will use it for and how they can access it. If it is sensitive information, we rely on you to have obtained consent to the above. If you have not done these things, we expect you to tell us before you provide the relevant information. If you collect, use, disclose, or handle personal information on our behalf, or receive it from us, you & your representatives must meet the relevant requirements of the NPP set out in the Privacy Act 1988 and only use and disclose it for the purposes we agree to.  **Transfer of information overseas**  We may transfer your personal information overseas where it is necessary to provide our service. Some insurers or reinsurer’s are based overseas and we need to provide your personal information to them to arrange your cover.  **Opting out**  We regularly distribute to our clients information about our products & services, such as newsletters, which we believe may be of interest to you. If you do not wish to receive this additional information, please contact our office. |